TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.

Main Office: 1405 Centerville Road, Suite 5400; Tallahassee, Florida 32308
Office: (850) 877-0101, Fax (850) 877-2750

Request to Complete Forms

I would like to have this form completed by my physician.
I understand I may be charged a fee of $30 (per set of forms) before forms can be processed.
Requests made by someone other than patient, parent/legal guardian will require a release.

Today's Date: _____ Person Completing form: _____

Patient's Name: _____ Patient DOB: _____

Start and end date of **time off to be considered** from work/school:

First Day off: _____ **Expected Return Date**: _____

I understand that the physician will make the final determination on the number of days/weeks that I will be out of school/work.

Form type (please circle one): FMLA INSURANCE DISABILITY SSA OTHER_____

Result of an accident? (Please circle one): YES NO Date of Accident: _____

If related to disability Occupation _____

Job Duties _____

_____

_____

Return of Form:

[ ] **EMAIL:** Please send the original form electronically to the following email._____

[ ] **FAX:** Please send the original form electronically to the following number._____

[ ] **MAIL**: Send the original form via U.S. mail to the following address:

_____

_____

_____

[ ] **COPY SENT TO ME:** Please send a copy of the form to me via MAIL or FAX to:

_____.

I understand that Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A is allowed 30 days to process my request for access of my information if maintained on-site, 60 days if the information is maintained off-site, and that the deadline may be extended an additional 30 days if notified in writing of the need for an extension. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

By signing below, I acknowledge and agree to the above conditions.

_____ _____
Signature Date

_____ [ ] Fees Collected [ ] ID Verified
Witness [ ] Patient will call with payment _____ (form taken by)

INTERNAL USE ONLY
Completed By: _____ Processed Date: _____ Called: _____

HIPAA Disclosure: _____ Due Date: _____